

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Comprehensive Medical and Dental Program (CMDP), 942C
P.O. Box 29202 • Phoenix, AZ 85038-9202 • (602) 351-2245
1-800-201-1795 • FAX (602) 351-8529

PRIOR AUTHORIZATION FOR MEDICAL/SURGICAL SERVICES

☐ INITIAL
☐ RENEWAL

PRIOR AUTHORIZATION NO. *(Submit on claim)*

PATIENT'S NAME <i>(Last, First, M.I.)</i>		BIRTHDATE	CMDP ID NO.	
CASE MANAGER'S NAME <i>(If known)</i>	PROG./AGENCY	PHONE NO.	DATE SERVICE TO BEGIN	TO END
REFERRING PHYSICIAN'S NAME <i>(Print or type)</i>		REFERRING PHYSICIAN'S SIGNATURE		PROVIDER ID NO.
REFERRING PHYSICIAN'S ADDRESS <i>(No., Street, City, State, ZIP)</i>				PHONE NO.
SERVICE RECOMMENDED	DIAGNOSIS			DATE OF YOUR LAST VISIT
				DATE OF RECOMMENDATION
SERVICE RATIONALE AND PROGNOSIS				

☐ Evaluation Attached

CHILD MUST BE ELIGIBLE ON DATE OF SERVICE/NON-EMERGENCY SERVICE MUST NOT BE SCHEDULED UNTIL AUTHORIZATION IS OBTAINED

PROVIDER'S NAME <i>(Last, First, M.I.)</i>			PROVIDER ID NO.	
PROVIDER'S ADDRESS <i>(No., Street, City, State, ZIP)</i>			PHONE NO.	
HCPCS/CPT	DESCRIPTION	CHARGES	U S C M D P O N L Y	ALLOWABLE FEES

☐ Evaluation Attached

I AGREE TO ACCEPT AS PAYMENT IN FULL THE AMOUNT PAID BY THE COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP) FOR SERVICES RENDERED TO AN ELIGIBLE FOSTER CHILD.

PHYSICIAN'S SIGNATURE	DATE
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FOR CMDP USE ONLY

AUTHORIZATION DATE	PENDED DATE	DENIAL DATE	REVIEWER'S NAME
PENDING ADDITIONAL INFORMATION (✓)			

- | | | |
|--|--|--|
| <input type="checkbox"/> HCPCS/CPT codes incomplete or incorrect | <input type="checkbox"/> Referring physician's signature | <input type="checkbox"/> Letter of medical diagnosis and necessity, supportive documentation |
| <input type="checkbox"/> Charges for medical services | <input type="checkbox"/> Provider's signature | <input type="checkbox"/> History and physical report |
| <input type="checkbox"/> Specific CMDP provider ID no. | <input type="checkbox"/> Child's CMDP ID no. | <input type="checkbox"/> Other <i>(Specify)</i> |
| <input type="checkbox"/> Specific provider's name | <input type="checkbox"/> Second opinion | |

This authorization is good only for the services specified for a 90-day period from the date of authorization.

DENIAL REASON

Completion Instructions for CMD-026-A
PRIOR AUTHORIZATION FOR MEDICAL/SURGICAL SERVICES

- A. Purpose. This form enables the **SERVICE PROVIDER** to request prior authorization for initial or ongoing services.
- B. Completion. The top portion must be completed by the REFERRING PHYSICIAN. The bottom portion must be completed by the **SERVICE PROVIDER** prior to submitting to the Prior Authorization Unit (CMDP), 942C.
- C. Routing. Send the original and all copies to CMDP, 942C.
- D. Retention. Retain the canary copy in the CMDP file according to CMDP policy. The referring physician and the service provider will receive copies for their records.